

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS63AGZ	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2010
NAME OF PROVIDER OR SUPPLIER MONTHILL PALMS		STREET ADDRESS, CITY, STATE, ZIP CODE 4062 MONTHILL LAS VEGAS, NV 89121		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of a required grading re-survey conducted in your facility on 11/30/10. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility received a re-survey grade of A. The facility is licensed for six Residential Facility for Group beds for persons with Alzheimer's disease, Category II residents. The census at the time of the survey was six. Six resident files were reviewed and four employee files were reviewed. The following deficiencies were identified:	Y 000		
Y 353 SS=E	449.222(3) Bathrooms and Toilet Facilities NAC 449.222 3. The bottoms of tubs and showers must have surfaces that inhibit falling and slipping. Cabinets that are attached to the floor or grab bars must be adjacent to the tubs, toilets and showers. This Regulation is not met as evidenced by: Based on observation on 11/30/10, the facility failed to ensure grab bars were provided adjacent to the toilet in 1 of 3 bathrooms (bathroom located down the hall from the kitchen). This was a repeat deficiency from the 7/20/10 state licensure survey.	Y 353		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Y 353	Continued From page 1 Severity: 2 Scope: 2	Y 353			

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